



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

HCA NORTHWEST REGIONAL HOSPITAL
3701 KIRBY DRIVE, SUITE 1288
HOUSTON, TX 77098-3926

Respondent Name

TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-04-5947-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary as stated on the Table Of Disputed Services: "Carrier authorized services, then denied claim alleging that the treatment and/or services have been determined unrelated to workers' compensation injury. Per meds, services are related to claimant's injury of 3/1/02. Also, carrier did not allow retrospective review for medical necessity of a medical bill for treatment for which preauth has been obtained per TWCC Rules 133.301(a) and 134.600(a)(2)."

Amount in Dispute: \$28,024.88

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The claimant developed unrelated complication to both feet after reaching MMI. Texas Mutual obtained a peer review and filed an additional TWCC 21 disputing medical and indemnity benefits related to sores and blisters on the bottom and insides of both feet as these conditions are not a direct and natural result of the injury, and are unrelated."

Response Submitted by: Texas Mutual Insurance Company, 221 W. 6th Street, Ste 300, Austin, TX 78701

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
February 03 – 28, 2003	Inpatient Surgery	\$28,024.88	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the

absence of an applicable fee guideline.

3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. This request for medical fee dispute resolution was received by the Division on February 3, 2004. Pursuant to 28 Texas Administrative Code §133.307(g)(3), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on February 09, 2004 to send additional documentation relevant to the fee dispute as set forth in the rule.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - R – Extent of Injury.
 - RA – The treatment/service has been determined to be unrelated to the extent of injury. Final adjudication has not taken place on this issue.

Findings

1. The insurance carrier denied disputed services with reason codes R – EXTENT OF INJURY and RA – THE TREATMENT/SERVICE HAS BEEN DETERMINED TO BE UNRELATED TO THE EXTENT OF INJURY. FINAL ADJUDICATION HAS NOT TAKEN PLACE ON THIS ISSUE.” Review of the medical bill finds that the principal diagnosis code is 728.86 – Necrotizing fasciitis.” A contested case hearing was held on September 28, 2004 to address the extent of injury issues regarding the injured worker’s compensable injury. As a result, a contested case hearing Decision was reached stating that the compensable injury of March 1, 2002 includes an injury to the right foot consisting of an ulceration and infection and an injury to the left foot consisting of an ulcer. The compensable injury of March 1, 2002 does not include osteomyelitis of the right foot. The issue of extent raised by the carrier on the explanation of benefit dated April 15, 2003 is resolved. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines
2. This dispute relates to services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.1, effective May 16, 2002, 27 *Texas Register* 4047, which requires that “Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers’ Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission.”
3. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual’s behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
4. 28 Texas Administrative Code §133.307(g)(3)(C)(ii), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send additional documentation relevant to the fee dispute including a statement of the disputed issue(s) that shall include “the requestor’s reasoning for why the disputed fees should be paid.” Review of the submitted documentation finds no documentation of the requestor’s reasoning for why the disputed fees should be paid. The Division concludes that the requestor has not met the requirements of §133.307(g)(3)(C)(ii).
5. 28 Texas Administrative Code §133.307(g)(3)(C)(iii), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send additional documentation relevant to the fee dispute including a statement of the disputed issue(s) that shall include “how the Texas Labor Code and commission [now the Division] rules, and fee guidelines, impact the disputed fee issues.” Review of the submitted documentation finds that the requestor did not state how the Texas Labor Code and Division rules impact the disputed fee issues. The Division concludes that the requestor has not met the requirements of §133.307(g)(3)(C)(iii).
6. 28 Texas Administrative Code §133.307(g)(3)(C)(iv), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires that the request shall include a position statement of the disputed issue(s) that shall include “how the submitted documentation supports the requestor position for each disputed fee issue.” Review of the requestor’s documentation finds that the requestor has not discussed how the submitted documentation supports the requestor position for each disputed fee issue. The Division concludes that the requestor has not met the requirements of §133.307(g)(3)(C)(iv).
7. 28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide “documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement.” Review of the submitted documentation finds that:
 - The requestor’s position statement does not articulate a methodology under which fair and reasonable reimbursement should be calculated.

- The requestor's rationale for increased reimbursement from the *Table of Disputed Services* asserts that "Carrier authorized services, then denied claim alleging that the treatment and/or services have been determined unrelated to workers' compensation injury. Per meds, services are related to claimant's injury of 3/1/02. Also, carrier did not allow retrospective review for medical necessity of a medical bill for treatment for which preauth has been obtained per TWCC Rules 133.301(a) and 134.600(a)(2)."
- The requestor did not provide documentation to demonstrate how it determined its usual and customary charges for the disputed services.
- Documentation of the amount of reimbursement received for these same or similar services was not presented for review.
- The Division has previously found that "hospital charges are not a valid indicator of a hospital's costs of providing services nor of what is being paid by other payors," as stated in the adoption preamble to the Division's former *Acute Care Inpatient Hospital Fee Guideline*, 22 *Texas Register* 6276. It further states that "Alternative methods of reimbursement were considered... and rejected because they use hospital charges as their basis and allow the hospitals to affect their reimbursement by inflating their charges..." 22 *Texas Register* 6268-6269. Therefore, the use of a hospital's "usual and customary" charges cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.
- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the services in dispute.

Authorized Signature

_____ Signature	_____ Medical Fee Dispute Resolution Officer	2/2/12 _____ Date
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_____ Signature	_____ Medical Fee Dispute Resolution Manager	2/2/12 _____ Date
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YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of

Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.